		& MEDICAID SERVICES			FEB 1 1 2014		MAPPROVED D. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY
		445464	B. WING			01	1/23/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	SI	FREET ADDRESS, CITY, STATE, ZIP CODE	1 0	172012014
HILLVIE	W HEALTH CENTER				666 HILLVIEW DRIVE LIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
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F 279		(1) DEVELOP	F 27	9	1/23/14 regarding trust accounts and surety bonds.		
		e results of the assessment	ATUDE		, TITLE		(X6) DATE
DOWNORT	λ - V	WSUPPLIER REPRESENTATIVES SIGN,	~10KE		HILE	^ -	(AU) DAIE

170ministrator ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: TN1002

FFR 1 1 7014

STATEMENT OF DETICIPACIES (ACI) PROVIDER CONDERSOR (ACI) PROVIDER SUPPLIER (ALTER) ALTER	CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB NC	0. 0938-0391
STREET ADDRESS, CITY, STATE, ZIP CODE 1668 HILLINEW MEALTH CENTER 1679 HILLINEW HEALTH CEN				1		E CONSTRUCTION		
HILLIVIEW HEALTH CENTER HILLIVIEW HEALTH CENTER STREET ADDRESS. CITY, STATE, ZIP-CODE 1996 FILLUTIEW CORN'E ELIZABETHTON, TN. 37843			445464	B. WING		 	01	/23/2014
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PREFIX TAG RESOLATORY ORLSC DETRIEVING INFORMATION) F 161 483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surely bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by. Based on review of the Trial Balance form for the resident trust accounts, the facility falled to ensure the Patient Fund Bond (surely bond) was sufficient to cover the amount of money in the resident furst accounts with resident furst accounts. The findings included: Review of the Trial Balance form dated January 23, 2014, revealed there were nine residents with trust fund accounts with a total of thirden thousand, three hundred, thirty-nine dollars, and eight cents (\$13,339.8). Review of the Patient Fund Bond revealed the bond amount was ten thousand dollars (\$10,000.00). Interview on January 23, 2014, at 9:25 a.m., with the Business Office Manager and the Administrator, in the Administrator's office, confirmed the Patient Fund Bond was not sufficient to cover the amount of money in the resident rust account. F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS Acalilly must use the results of the assessment and the survey statement and bridging with a saterisk (7) denotes a deficiency which the inclitution may be excused from correction providing it is determined that resafeguards provide sufficient to the patients. (See instructions). Except for rursing homes, the above indiges and plane a correction are disclosable 90 days with the facility relations and planes. The coordinators are decidenable and correction are disclosable 90 days without and correction are disclosable 90 days with the account of the patients. (See instructions). Except for rursing homes, the findings and plane account of correction are disclosable 90 days.	(VA) ID	SUMMADV ST	ATEMENT OF DESIGNATION					
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ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued	lowing the d	late of survey whether or :	not a plan of correction is provided. Fo	r nursing h	nome	es, the above findings and plans of correction	n are disc	losable 14

RM CMS-2567(02-99) Previous Versions Obsolete

ogram participation.

Event ID:5HVZ11

Facility ID: TN1002

If continuation sheet Page 1 of 5

CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES		_		OMB N	O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		PLE CONSTRUCTION G	(X3) E	(X3) DATE SURVEY COMPLETED	
·		445464	B. WING	;_			1/23/2014	
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
HILLVIE	W HEALTH CENTER			ľ	1666 HILLVIEW DRIVE	-		
	<u> </u>				ELIZABETHTON, TN 37643			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE	(X5) COMPLETION DATE	
SS=0	The facility must purotherwise provide a Secretary, to assure funds of residents of This REQUIREMENT by: Based on review of resident trust account trust fund accounts thousand, three hunding trust fund accounts thousand, three hunding trust fund accounts thousand, three hunding trust fund account thousand, three hunding trust fund account (\$10,000.00). Interview on January the Business Office Administrator, in the confirmed the Patier sufficient to cover the resident trust account 483.20(d), 483.20(k) COMPREHENSIVE	rchase a surety bond, or assurance satisfactory to the eight security of all personal deposited with the facility. It is not met as evidenced if the Trial Balance form for the ents, the facility failed to Fund Bond (surety bond) was ne amount of money in the ent for nine of nine residents accounts. Balance form dated January there were nine residents with with a total of thirteen dred, thirty-nine dollars, and 2.08). In Fund Bond revealed the enthousand dollars y 23, 2014, at 9:25 a.m., with Manager and the Administrator's office, at Fund Bond was not ne amount of money in the ent. (1) DEVELOP	F 2	79	Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and Activities Director.			
BORATORY		R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE		, TITLE		(X6) DATE	
	Vor		· · ·	ſ	Himin i Chimhair	2-	7-14	
y deficienc	y statement eading with an	n asterisk (*) denotes a deficiency which	h the inst	ituti	ion may be excused from correcting providi	ng it is det	ermined that	

ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

RM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE & MEDICAID SERVICES

Event ID:5HVZ11

Facility ID: TN1002

If continuation sheet Page 1 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	. 01,30,2014 1APPROVED 2 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED	
		445464	B. WING	;_		01.	/23/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2014
HILLVIE	W HEALTH CENTER		j	1	1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
F 279	The facility must der plan for each reside objectives and timel medical, nursing, ar needs that are ident assessment. The care plan must to be furnished to at highest practicable ppsychosocial well-be §483.25; and any se be required under §due to the resident's	red revise the resident's of care. velop a comprehensive care on that includes measurable ables to meet a resident's of mental and psychosocial ified in the comprehensive describe the services that are tain or maintain the resident's obysical, mental, and sing as required under evices that would otherwise 183.25 but are not provided exercise of rights under the right to refuse treatment.	F2	279	The Minimum Data Set Coordinator updated Resident #10's care plan to reflect weigh loss on 1/23/2014. The Current Care Plans of residents with weight loss were reviewed by the Minimum Data Set Coordinators on 1/27/2014 ensure weight loss was address No other residents were found to be affected. The Minimum Data Set Coordinators were in-serviced to Director of Nursing on 1/23/20 on updating care plans to reflect weight loss as appropriate.	e a to ed. to by	217/14
	by: Based on medical reand interview, the far plan for weight loss of thirty-one residents of the findings included Resident #10 was acceptember 30, 2013 Fractured Femur, DeFibrillation. Medical record review December 17, 2013, (weight) 144# (pound	d: Imitted to the facility on with diagnoses including mentia, Anemia, and Atrial of a dietary note dated revealed "December wt			The Minimum Data Set Coordinators will review 100% care plans of residents with weight loss weekly x 4 weeks, then monthly x 2 months and/or 100% compliance. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consis of the Administrator, Director of Nursing, Minimum Data Set Coordinators, Rehabilitation Manager, Medical Director,	its	

		& MEDICAID SERVICES			FORM APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445464	B. WING		01/23/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0 172372014
HILLVIE	W HEALTH CENTER			1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, and a second control of the contro	BE COMPLETION
F 325 SS=D	care) including fortif day) providing: 2535 pro(protein)/day. Me with current intake/p will recommend hou qid (four times a day pro/day to prevent fu. Medical record revie on January 13, 2014 address the resident Observation on January 13, 2014 address the resident breakfast of scrambl toast, juice, oatmeal, Interview on January the DON (Director of room, confirmed a cadeveloped for weight 483.25(i) MAINTAIN UNLESS UNAVOIDABBased on a resident's assessment, the facil resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that thi	below nutrition poc (plan of led foods tid (three times a cal (calories), 98 gm (grams) leting est (estimated) needs ocsince wt loss (continues) se supplement 2 oz (ounces) to provide 480 cal, 20 gm orther wt loss" w of the care plan reviewed revealed no care plan to sweight loss. lary 23, 2014, at 8:00 a.m., t sitting up in bed eating ed eggs, whole milk, apples, bacon, and coffee. 23, 2014, at 8:10 a.m., with Nursing), in the conference are plan had not been loss. NUTRITION STATUS BLE s comprehensive ity must ensure that a lable parameters of nutritional weight and protein levels, clinical condition	F 32	Social Services Director, Environmental Services Director Maintenance Director, Dietary Manager, and Activities Director Physician Order on 1/23/2014 reflecting Registered Dietician Recommendation for Resident #10 made on 12/17/2013. Responsible Party was notified of 1/23/14 by the Director of Nursing. The Dietary Manager and the Director of Nursing reviewed previous six months of Registere Dietician Recommendations and	d H
	/02.99\ Pravious Versions Ob			resident records to ensure	

DEL ALVIMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C		M APPROVEI D. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		445464	B. WING		<u> </u>	0	112212044
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1/23/2014
HILLVIE	W HEALTH CENTER				66 HILLVIEW DRIVE IZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
	by: Based on medical rand interview, the fadietary recommendathree residents reviet thirty-one residents The findings include Resident #10 was a September 30, 2013 Fractured Femur, De Fibrillation. Medical record reviet Review and Assessing revealed "IWR (ide 108-132weight state past 3 monthsIntalestimated needs" Medical record reviet December 17, 2013, (weight) 144# (pound 12#/7.69% x 1 mo (number 7 day review of becare) including fortified day) providing: 2535 pro(protein)/day. Med with current intake/powill recommend house qid (four times a day) pro/day to prevent fur Medical record review January 7, 2014, revewelled including fortified with the current intake/powill recommend house qid (four times a day) pro/day to prevent fur Medical record review January 7, 2014, revewelled including since its model of the cord review January 7, 2014, revewelled in the cord review January 7, 2014, reve	record review, observation, icility failed to follow up on a action for one resident (#10) of ewed for weight loss of reviewed. d: dmitted to the facility on B, with diagnoses including ementia, Anemia, and Atrial w of the Nutritional Risk ment dated October 7, 2013, eal weight range) tus gain or loss stable within the meets 50-75% of w of a dietary note dated revealed "December wt dis) Significant wt loss month)eating 65% average elow nutrition poc (plan of ed foods tid (three times a cal (calories), 98 gm (grams) eting est (estimated) needs ocsince wt loss (continues) is supplement 2 oz (ounces) to provide 480 cal, 20 gm	F 3:	25	Registered Dietician Recommendations had been followed on 1/23/14. No other residents were found to be affected. The Director of Nursing and Dietary Manager were in-servic by the Regional Director of Clinical Services on 1/23/2014 Registered Dietician Recommendation follow up. The Director of Nursing will review 100% of Registered Dietician Recommendations weekly x 4 weeks, then monthly 2 months and/or 100% compliance. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consist of the Administrator, Director of Nursing, Minimum Data Set Coordinators, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director Maintenance Director, Dietary Manager, and Activities Director	ced on y x sts f	

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FORM APPROVED

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING). 0938-0391 TE SURVEY MPLETED
		445464	B. WING	s		01/23/2014	
NAME OF	PROVIDER OR SUPPLIER			Τ,	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	123/2014
HILLVIE	W HEALTH CENTER			1	1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES					
PRÉFIX TAG	! (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RF	(X5) COMPLETION DATE
	Continued From par last reviewcontinu	ge 4 e current nutrition poc"	F3	325		y	
,	and January 2014, I Record revealed no supplement had bee Observation on January revealed the resident breakfast of scramb toast, juice, oatmeal Interview on January	uary 23, 2014, at 8:00 a.m., at sitting up in bed eating led eggs, whole milk, apples, bacon, and coffee.		<u> </u>			
	responsible for the reconfirmed the reside nutritional supplementational supplementation of the DON (Director of room, confirmed the	tical Nurse) #1 (nurse esident), in the hall, ont was not receiving a					
1	terephone, with the Reconfirmed was aware received the house si recommended the house of the hou	the resident had not upplement, and had puse supplement in the resident's continued and interview confirmed the stable in January and the sting estimated needs					
M CMS-2567	(02-99) Previous Versions Ob	solete Event ID:5HVZ11	F	acilit	y ID: TN1002 If continuati	on sheet	Page 5 of 5

SELECTION OF THEALTH AND HUMAN SERVICES